

Strategic Plan for Children's Behavioral Health

Goal	Steps or Strategies	Interventions/Activities	Measures
<p>1. Healthy, strong, resilient, stable families as evidenced by children who:</p> <p>A. Live in a safe, nurturing home</p> <p>B. Attend school</p> <p>C. Make educational progress</p> <p>D. Are involved in positive peer activities</p> <p>E. Can have their needs for healthy development met in their homes and communities</p>	<p>1. Create local or regional systems of care by:</p> <p>A. Building the capacity of the children's behavioral health system</p>	<p>1.A.1. Create a \$6 million fund to provide incentive grants to start up new behavioral health services, particularly mid-level services such as:</p> <ul style="list-style-type: none"> Wrap-around Day treatment After-school behavioral health programs Intensive outpatient programs Crisis intervention programs Respite care In-home family therapy Intensive case management Mobile crisis teams Drop-in centers for teens Co-occurring disorders clinics <p>1.A.2. Encourage DMAS to fund mid-level services in the Medicaid state plan</p> <p>1.A.3. Encourage DMAS to fund the adolescent substance abuse services outlined in the current Medicaid state plan</p> <p>1.A.4. Encourage DMAS to suspend rather than end Medicaid benefits when a youth is placed in detention</p> <p>1.A.5. Provide mental health services in all remaining juvenile detention centers without such services @ \$1 million</p>	<p>1.A.1. There will be a proportional increase in utilization of middle intensity behavioral health services and decrease in the use of high level services</p> <p>1.A.2. There will be a decrease in days children spend in out-of-home placements</p> <p>1.A.3. There will be a decrease in days children spend in out-of-community placements</p> <p>1.A.5.a. There will be fewer admissions to detention centers for youth with primary MH and SA problems</p> <p>1.A.5.b. There will be decreased recidivism to detention centers for youth with primary MH and SA problems</p>

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	1.B. Building the workforce of the children's behavioral health system	<p>1.A.6. Fully fund Part C early intervention services</p> <p>1.A.7. Authorize the Office of Comprehensive Services to use CSA funds flexibly to help start up new services and programs</p> <p>1.B.1. Establish a university-based teaching center to organize and lead the training of clinicians in evidence-based, promising and best practices for children's behavioral health treatment across the Commonwealth</p> <p>1.B.2. Fund four child psychiatry fellowship and four child psychology internship slots @ \$500,000 with payback provisions to work in an underserved area in Virginia</p> <p>1.B.3. Fund five regional trainings in evidence-based children's behavioral health services for behavioral health clinicians @ \$600,000</p> <p>1.B.4. Fund five regional trainings in children's behavioral health services for pediatricians and family practitioners @ \$600,000</p> <p>1.B.5. Provide local and regional trainings in how to do wraparound services</p>	<p>1.B.2.a. There will be an increase in practicing child psychiatrists in Virginia</p> <p>1.B.2.b. There will be an increase in practicing child psychologists in Virginia</p> <p>1.B.4. 100 pediatricians and family practitioners will receive training in children's behavioral health through the efforts of the university-based teaching center</p>

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	<p>1.C. Service agencies communicate and collaborate to meet those needs</p> <p>1.D. Services can be accessed through any door</p> <p>2. Maximize the use of EPSDT screenings</p>	<p>1.C.1. Provide reimbursement for care coordination and interagency communication between providers</p> <p>1.C.2. Allow public-private partnerships to jointly apply for state funds</p> <p>1.C.3. DMHMRSAS will develop criteria to identify local Centers of Excellence in systems of care</p> <p>1.C.4. Fund mentorship/training from local Centers of Excellence to similar communities</p> <p>1.C.5. Utilize one lead case manager/care coordinator per family</p> <p>1.C.6. Co-locate providers and agencies and align infrastructure to support collaboration</p> <p>1.D.1. Develop and implement a single intake instrument for families for use by DMHMRSAS, DSS, DJJ, DOE, and CSA</p> <p>1.D.2. Develop and implement a uniform management information system for use by DMHMRSAS, DSS, DJJ, DOE, and CSA</p> <p>2. Provide regional trainings on EPSDT to pediatricians and family practitioners</p>	<p>1.C.3. The DMHMRSAS will identify two Centers of Excellence that have developed systems of care</p> <p>2.A. There will be an increase in the number of children receiving EPSDT screenings</p> <p>2.B. There will be an increase in the number of services authorized by EPSDT screenings</p>

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	<p>3. DMHMRSAS and DOE will collaborate to develop and implement strategies to keep children with behavioral health problems in school rather than suspend or expel them.</p> <p>4. DMHMRSAS, DSS and CSA will collaborate to develop and implement strategies to prevent children from being placed in DSS custody solely to access behavioral health services</p> <p>5. DMHMRSAS, DSS, and DOE collaborate on new child abuse prevention efforts</p>	<p>3.A. Provide school-based mental health clinicians in 20 middle schools in five regions @ \$1.8 million</p> <p>3.B. Fund bullying prevention programs in schools</p> <p>4.A. DSS will eliminate the practice of placing children in DSS custody solely so that they may access behavioral health services</p> <p>4.B. FAPT teams will be required to serve all children at risk of out of home placement for behavioral health problems</p> <p>5.A. Fund pilots for Nurse Home Visitation programs</p> <p>5.B. Fund pilots for Child-Parent Centers in preschools and elementary schools in high-risk neighborhoods</p> <p>5.C. Evaluate the outcomes of the existing child abuse and neglect prevention programs in Virginia and compare them with the outcomes of evidence-based programs</p>	<p>3.A.1. There will be a decrease in the number of school suspensions of children with primary MH and SA problems</p> <p>3.A.2. There will be a decrease in the number of school expulsions of children with primary MH and SA problems</p> <p>3.A.3. There will be a decrease in the school drop out rate for children with primary MH and SA problems from schools</p> <p>4.A. No children will be placed in DSS custody solely to access and receive behavioral health services</p> <p>4.B. The number of children served by CSA who are not in DSS custody will increase</p> <p>5.A.1. The numbers of children alleged to be abused or neglected will decrease</p> <p>5.A.2. The numbers of children substantiated as abused or neglected will decrease</p> <p>5.C. Initiatives that do not demonstrate reductions of child abuse and neglect will be replaced with evidence-based and promising programs</p>

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<p>2. Equitable access to services without regard to racial/ethnic status, socioeconomic status, and geographic location as evidenced by:</p> <p>A. All children have health insurance</p> <p>2.B. Mental health and substance abuse parity in insurance</p> <p>2.C. Children and families have access to behavioral health services and supports when they need them</p>	<p>2.A. Examine the current health insurance model in Virginia and other states to determine the best approaches to increase the number of children with health insurance</p> <p>2.B. Expand the number of private insurers who offer mental health and substance abuse parity</p> <p>2.C.1. Enact the original intent of the Comprehensive Services Act to serve at-risk children with behavioral health problems using a system of care approach</p>	<p>2.A.1. Increase the eligibility level for FAMIS to 200% of poverty</p> <p>2.A.2. Examine the Massachusetts model for providing health insurance to all children to determine if it can be replicated in Virginia</p> <p>2.A.3. Promote legislation that provides health insurance for all of Virginia's children</p> <p>2.B. Educate private insurers regarding the cost offsets and positive economic impact of insurance coverage for mental health and substance abuse</p> <p>2.C.1.a. FAPT teams will be required to serve all children at risk of out of home placement for behavioral health problems</p> <p>2.C.1.b. The Office of Comprehensive Services will eliminate the distinction between mandated and non-mandated children</p>	<p>2.A.1. There will be an increase in the number of children enrolled in FAMIS</p> <p>2.A.3. Increase the percentage of children with health insurance</p> <p>2.B. Increase the number of health insurance programs in Virginia that offer parity for mental health and substance abuse</p> <p>2.C.1.a. There will be an increase in the number of communities that have strong systems of care to meet the behavioral health needs of children and families</p>

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	2.C.2. Provide a public safety net for the mental health, substance abuse and mental retardation needs of children and their families	<p>2.C.2.a. Provide public and private agencies that subscribe to SOC principles @ \$6/ million in additional funding to start up new behavioral health services, particularly mid-level service such as:</p> <ul style="list-style-type: none"> Wrap-around Day treatment After-school behavioral health programs Intensive outpatient programs Crisis intervention programs Respite care In-home family therapy Intensive case management Mobile crisis teams Drop-in centers for teens Co-occurring disorders clinics <p>2.C.2.b. Fund system of care pilot projects in 50% of Virginia communities @ \$500,000 for each of two years</p> <p>2.C.2.c. All Community Service Boards will have a designated child and adolescent service provider for mental health, mental retardation, and substance abuse services</p> <p>2.C.2.d. Increase Medicaid reimbursement rates for behavioral health care, particularly for:</p> <ul style="list-style-type: none"> Outpatient psychiatry Primary care physicians who provide behavioral health services Acute in-patient hospitalization Day treatment services Intensive in-home family services 	<p>2.C.2.a.1. Families and children with behavioral health emergencies will receive services immediately</p> <p>2.C.2.a.2. Families and children in urgent crises will receive services within 24 hours of initial contact</p> <p>2.C.2.a.3. All families and children in need of behavioral health services will receive them within two weeks of initial contact</p>

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	<p>2.C.3. Strengthen family-professional partnerships to improve access to services</p>	<p>2.C.3.a. Fund a statewide family education, information and support network @ \$500,000 to develop strong collaborative partnerships between family organizations, individual family members, professionals, and state agency representatives</p> <p>2.C.3.b. Expand and sustain membership of families and youth on local, regional and state boards, councils and committees that make decisions about children's behavioral health services, thereby ensuring authentic involvement of families in policy development that impacts service development in the Commonwealth</p>	<p>2.C.3.b. There will be an increased number of family and youth memberships on local, regional and state boards, councils and committees that make decisions about behavioral health services for children and families</p>

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<p>3. Children are provided with humane, least-restrictive, and effective services that support healthy child development as evidenced by:</p> <p>Children's needs are accurately assessed</p> <p>Children's needs are matched to appropriate treatment interventions and levels of care</p> <p>Family and child preferences and strengths are driving forces treatment planning</p> <p>Clinicians and treatment programs utilize evidence-based, promising, and best practices</p>	<p>3.A.1. Develop and distribute standards for uniform screening and comprehensive assessment</p> <p>3.A.2. Provide training in the standards for uniform screening and comprehensive assessment</p> <p>3.A.3. Screening tools will match children's needs and strengths to appropriate treatments and levels of care</p> <p>3.A.4. Comprehensive assessments will be behavioral, functional and strengths-based</p>	<p>3.A.1.a. Identify a uniform screening tool to match children in need of behavioral health services to the appropriate levels and types of treatment</p> <p>3.A.1.b. Identify uniform assessment tools for behavioral health clinicians that support appropriate treatment interventions that are strengths-based, utilize evidence-based and promising practices, and accurately assess children's needs and required levels of care</p> <p>3.A.2. Fund statewide trainings on uniform assessment tools @ \$600,000</p> <p>3.A.4.a. Implement uniform assessment tools statewide to accurately assess all areas of the child's and family's needs including home, school, and community @ \$500,000</p> <p>3.A.4.b.. The uniform assessment tools selected will be placed in the statewide, shared Management Information System referenced in 1.D.2</p>	<p>3.A.4.a.1. There will be an increase in the use of uniform assessment tools that accurately assess children's needs and strengths and required levels of care</p> <p>3.A.4.a.2. All CSBs will implement uniform assessment tools for evaluating children's needs, strengths and required levels of care</p>

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	<p>3.A.5. Comprehensive assessments will reflect family and child preferences</p> <p>3.A.6. Comprehensive assessments will include community-based recommendations for the least restrictive, most normative environment that is clinically appropriate</p> <p>3.B.1. Promote the use of evidence-based and promising practices</p> <p>3.B.2. Train clinicians on evidence-based treatment models</p>	<p>3.B.1.a. Update the Commission on Youth (COY) website on evidence-based practices annually</p> <p>3.B.1.b. Disseminate new evidence-based treatments to CSBs annually</p> <p>3.B.1.c. Expand the COY website to include promising practices</p> <p>3.B.1.d. Provide technical assistance in evidence-based practices by doing on-site visits to each CSB annually</p> <p>3.B.1.e. Establish a fund in the OCFS in DMHMRSAS to offset costs of licensure, training and supervision in evidence-based practices</p> <p>3.B.2. Hold alternating annual conferences on systems of care and evidence-based practices in the treatment of children with mental health, mental retardation and substance abuse problems</p>	<p>3.B.1.a. There will be an increase in the number of Virginians who visit the Commission on Youth website annually</p> <p>3.B.1.e. Each CSB will implement one new evidence-based practice</p> <p>3.B.2.a. There will be a decrease in days children spend in out-of-home placement</p> <p>3.B.2.b. There will be a decrease in days children spend in out-of-community placements</p>

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	3.C. Develop and implement uniform statewide performance measures and an evaluation/monitoring process for children's behavioral health services	<p>3.C.1. Fund the development and annual project management costs of a data management system for children's behavioral health outcomes @ \$500,000</p> <p>3.C.2. All entities receiving funding for children's behavioral health services will be required to collect and report data elements and outcome measures specific to children's behavioral health services in their contracts</p> <p>3.C.3. Outcome data will be reported to DMHMRSAS quarterly</p> <p>3.C.4. The outcome measures will be built into the statewide MIS referenced in 1.D.2</p>	<p>3.B.2.c. There will be a decrease in admissions to detention centers for youth with primary mental health and substance abuse problems</p> <p>3.C.2. Entities receiving funding for children's behavioral health services will be in full compliance with federal and state requirements</p>